

		FOR OHF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0036152</u> Facility Name: <u>Rosewood Care Center-Moline</u> Address: <u>7300 Thirty Fourth Avenue</u> <u>Moline</u> <u>61265</u> <div style="display: flex; justify-content: space-between; width: 100%;"> Number City Zip Code </div> County: <u>Rock Island</u> Telephone Number: <u>(309) 792-5940</u> Fax # <u>()</u> IDPA ID Number: <u>431453169001</u> Date of Initial License for Current Owners: <u>05/06/90</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

SEE ACCOUNTANTS' COMPILATION REPORT

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Rosewood Care Center-Moline# 0036152 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>10,769</u>	<u>10,769</u>	8
9	SNF/PED					9
10	ICF	<u>3,434</u>	<u>22,390</u>		<u>25,824</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,434</u>	<u>22,390</u>	<u>10,769</u>	<u>36,593</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 83.32%)D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 05/07/90J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/07/90 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 42 and days of care provided 10769Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2000 Fiscal Year: 06/30/2000* All facilities other than governmental must report on the accrual basis.
SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **Rosewood Care Center-Moline** # **0036152** Report Period Beginning: **07/01/1999** Ending: **06/30/2000**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	172,282	17,433	7,781	197,496		197,496	0	197,496		1
2	Food Purchase		179,271		179,271		179,271	(13,241)	166,030		2
3	Housekeeping	112,123	25,541		137,664		137,664	0	137,664		3
4	Laundry	41,347	20,081		61,428		61,428	0	61,428		4
5	Heat and Other Utilities			97,024	97,024		97,024	0	97,024		5
6	Maintenance	19,130	12,602	63,965	95,697		95,697	3,440	99,137		6
7	Other (specify): Sanitation			19,413	19,413		19,413	0	19,413		7
8	TOTAL General Services	344,882	254,928	188,183	787,993		787,993	(9,801)	778,192		8
	B. Health Care and Programs										
9	Medical Director			12,063	12,063		12,063	0	12,063		9
10	Nursing and Medical Records	1,451,173	165,219	73,568	1,689,960		1,689,960	0	1,689,960		10
10a	Therapy	49,929	1,781	679,286	730,996		730,996	(176,544)	554,452		10a
11	Activities	43,310	3,221	2,063	48,594		48,594	0	48,594		11
12	Social Services	40,989		2,220	43,209		43,209	0	43,209		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	1,585,401	170,221	769,200	2,524,822		2,524,822	(176,544)	2,348,278		16
	C. General Administration										
17	Administrative			677,372	677,372		677,372	(582,999)	94,373		17
18	Directors Fees							0			18
19	Professional Services			4,903	4,903		4,903	57,299	62,202		19
20	Dues, Fees, Subscriptions & Promotions			25,048	25,048		25,048	(8,547)	16,501		20
21	Clerical & General Office Expense	102,234	29,593	22,733	154,560		154,560	205,981	360,541		21
22	Employee Benefits & Payroll Taxes			274,185	274,185		274,185	26,362	300,547		22
23	Inservice Training & Education							0			23
24	Travel and Seminar			1,549	1,549		1,549	(84)	1,465		24
25	Other Admin. Staff Transportation			6,657	6,657		6,657	14,497	21,154		25
26	Insurance-Prop.Liab.Malpractice			28,770	28,770		28,770	3,981	32,751		26
27	Other (specify):*							0			27
28	TOTAL General Administration	102,234	29,593	1,041,217	1,173,044		1,173,044	(283,510)	889,534		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,032,517	454,742	1,998,600	4,485,859		4,485,859	(469,855)	4,016,004		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Rosewood Care Center-Moline

0036152

Report Period Beginning: 07/01/1999 Ending: 06/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			10,652	10,652		10,652	160,879	171,531		30
31	Amortization of Pre-Op. & Org.							10,948	10,948		31
32	Interest			55,360	55,360		55,360	627,619	682,979		32
33	Real Estate Taxes			93,243	93,243		93,243	0	93,243		33
34	Rent-Facility & Grounds			1,289,341	1,289,341		1,289,341	(1,278,315)	11,026		34
35	Rent-Equipment & Vehicles							0			35
36	Other (specify):*							0			36
37	TOTAL Ownership			1,448,596	1,448,596		1,448,596	(478,869)	969,727		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		110,366	21,075	131,441		131,441	(684)	130,757		39
40	Barber and Beauty Shops			13,618	13,618		13,618	0	13,618		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			65,880	65,880		65,880	0	65,880		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers		110,366	100,573	210,939		210,939	(684)	210,255		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,032,517	565,108	3,547,769	6,145,394	0	6,145,394	(949,408)	5,195,986		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **Rosewood Care Center-Moline**

0036152

Report Period Beginning: **07/01/1999**

Ending: **6/30/2000**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals	(12,700)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(684)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(541)	2		13
14	Non-Care Related Interest	(55,360)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(84)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,947)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,600)	20		28
29	Other-Attach Schedule <u>Marketing Salary</u>	(28,768)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (106,684)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(842,724)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (842,724)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (949,408)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Rosewood Care Center-Moline

0036152 Report Period Beginning:

07/01/1999

Ending: 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
A. General Services												
1 Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2 Food Purchase	(13,241)	0	0	0	0	0	0	0	0	0	0	(13,241) 2
3 Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4 Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5 Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6 Maintenance	0	0	3,440	0	0	0	0	0	0	0	0	3,440 6
7 Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8 TOTAL General Services	(13,241)	0	3,440	0	0	0	0	0	0	0	0	(9,801) 8
B. Health Care and Programs												
9 Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10 Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a Therapy	0	(176,544)	0	0	0	0	0	0	0	0	0	(176,544) 10a
11 Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12 Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13 Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14 Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15 Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16 TOTAL Health Care and Program	0	(176,544)	0	0	0	0	0	0	0	0	0	(176,544) 16
C. General Administration												
17 Administrative	0	(657,372)	74,373	0	0	0	0	0	0	0	0	(582,999) 17
18 Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19 Professional Services	0	1,394	55,905	0	0	0	0	0	0	0	0	57,299 19
20 Fees, Subscriptions & Promotions	(8,547)	0	0	0	0	0	0	0	0	0	0	(8,547) 20
21 Clerical & General Office Expenses	(28,768)	141	234,608	0	0	0	0	0	0	0	0	205,981 21
22 Employee Benefits & Payroll Taxes	0	290	26,072	0	0	0	0	0	0	0	0	26,362 22
23 Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24 Travel and Seminar	(84)	0	0	0	0	0	0	0	0	0	0	(84) 24
25 Other Admin. Staff Transportation	0	0	14,497	0	0	0	0	0	0	0	0	14,497 25
26 Insurance-Prop.Liab.Malpractice	0	0	3,981	0	0	0	0	0	0	0	0	3,981 26
27 Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28 TOTAL General Administration	(37,399)	(655,547)	409,436	0	0	0	0	0	0	0	0	(283,510) 28
TOTAL Operating Expense												
29 (sum of lines 8,16 & 28)	(50,640)	(832,091)	412,876	0	0	0	0	0	0	0	0	(469,855) 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

Summary B

0036152

07/01/1999 Ending:

06/30/2000

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[illegible]

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number: **Reverend Care Center-Medina**

STATE OF ILLINOIS
ID: 00000002

Report Period Beginning: 07/01/1999

End Date: 06/30/2000

Page 6

Show Pgs 6A thru 6

Show Pgs 6B thru 6

Hide Pgs 6A thru 6

VI. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

OWNERS		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES	
Name	Ownership %	Name	City	Name	City
Larry Vander Mate	75.00%				
David Haddley	25.00%				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.
☒ Yes ☐ No

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

Schedule	Line	Item	Amount	Name of Related Organization	% of Ownership	Operating Costs of Related Organization	Adjustments for Related Organization Costs
V	1	Management Fee	177,272	RCM Management Services, Inc.	100.00%		177,272
V	2	Therapy	176,260	Reverend Therapy Company, Inc.	10.00%	881,723	176,260
V	3	Rent	1,280,343	Medina Real Estate, Inc.	10.00%	113,809	1,166,534
V	4	Insurance		Medina Real Estate, Inc.		113,809	1,166,534
V	5	Utilities		Medina Real Estate, Inc.		113,809	1,166,534
V	6	Telephone		Medina Real Estate, Inc.		113,809	1,166,534
V	7	Supplies		Medina Real Estate, Inc.		113,809	1,166,534
V	8	Professional Fees		Medina Real Estate, Inc.		113,809	1,166,534
V	9	Travel		Medina Real Estate, Inc.		113,809	1,166,534
V	10	Office Expenses		Medina Real Estate, Inc.		113,809	1,166,534
V	11	Other		Medina Real Estate, Inc.		113,809	1,166,534
V	12	Total	2,634,875			1,280,343	1,280,343

Print Preview

Sum, 6

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Total must agree with the amount recorded on line 30 of Schedule V.

SEE ACCOUNTANT'S COMPILATION REPORT.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.

2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.

3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.

4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.

5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 74,373	74,373
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	234,608	234,608
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	26,072	26,072
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	14,497	14,497
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	21,070	21,070
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	11,026	11,026
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	55,905	55,905
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	3,981	3,981
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	3,440	3,440
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 444,972	\$ * 444,972

Sum_6A

74373
234608
26072
14497
21070
11026
55905
3981
3440

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number Rosewood Care Center-Moline

0036152

Report Period Beginn 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	440,066	3	6.94%	Salary	\$ 29,746	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	157,353	3	6.94%	Salary	13,916	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,662		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORT

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number Rosewood Care Center-Moline# 0036152 Report Period Beginning: 07/01/1999Ending: 5/30/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HSM Management Services, Inc.Street Address 11701 Borman Drive, Suite 315City / State / Zip Code St. Louis, MO 63146Phone Number (314) 994-9070Fax Number (314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation	
Line	Item	(i.e.,Days, Direct Cost	Total Units	Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6	Units		
1	17	Salaries - Officers	Total Cost	17	\$ 341,083	\$ 341,083	4,393,278	\$ 23,662	1
2	21	Salaries - Other	Total Cost	17	2,916,125	2,916,125	4,393,278	202,301	2
3	22	Payroll Taxes	Total Cost	17	221,266		4,393,278	15,350	3
4	22	Employee Benefits	Total Cost	17	87,376		4,393,278	6,062	4
5	25	Travel	Total Cost	17	123,502		4,393,278	8,568	5
6	30	Depreciation	Total Cost	17	273,812		4,393,278	18,995	6
7	34	Building Rent	Total Cost	17	158,940		4,393,278	11,026	7
8	19	Professional Services	Total Cost	17	805,860		4,393,278	55,905	8
9	21	Telephone	Total Cost	17	167,133		4,393,278	11,595	9
10	26	Insurance	Total Cost	17	57,385		4,393,278	3,981	10
11	21	Taxes & Licenses	Total Cost	17	7,008		4,393,278	486	11
12	21	Office Supplies	Total Cost	17	291,559		4,393,278	20,226	12
13	6	Maintenance	Total Cost	17	46,996		4,393,278	3,260	13
14	17	Direct - Admin	Direct Cost	1	50,711	50,711	1	50,711	14
15	17	Direct - Admin	Direct Cost	16	917,842	917,842	0	0	15
16	22	Direct - Payroll Taxes	Direct Cost	1	4,660		1	4,660	16
17	22	Direct - Payroll Taxes	Direct Cost	16	93,517		0	0	17
18	30	Direct - Depreciation	Direct Cost	1	2,075		1	2,075	18
19	30	Direct - Depreciation	Direct Cost	16	30,435		0	0	19
20	25	Direct - Travel	Direct Cost	1	5,929		1	5,929	20
21	25	Direct - Travel	Direct Cost	16	227,870		0	0	21
22	6	Maintenance	Direct Cost	1	180		1	180	22
23	6	Maintenance	Direct Cost	16	8,249		0	0	23
24									24
25	TOTALS				\$ 6,839,513	\$ 4,225,761		\$ 444,972	25

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bonds		X	Mortgage		12/21/93	\$ 5,500,000	\$ 0	N/A	7.25%	\$ 86,245	1	
2	Bank of America		X	Mortgage Refinancing	\$85,767.00	10/26/99	10,312,500	10,253,217	11/2009	8.89%	629,791	2	
3	Less: Related Party Interest										(33,057)	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$85,767.00		\$ 15,812,500	\$ 10,253,217			\$ 682,979	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 15,812,500	\$ 10,253,217			\$ 682,979	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number **Rosewood Care Center-Moline**# **0036152** Report Period Beginning: **07/01/1999** Ending: **06/30/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	106,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	85,743	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(20,257)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	113,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	93,243	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	1996	1997	1998	1999
	95,009	92,263	85,527	84,641	89,050
	8	9	10	11	12

1998 Payment \$63,480
1999 Payment \$22,262
Accrual = Remaining 1999 payment (66,787) + 1/2 of estimated 2000 tax bill (46,713)

FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATIC \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO
If so, please complete the following:1. Total Amount Incurred: \$244,250 2. Number of Years Over Which it is Being Amortized Bond Fees - 20 Yrs; Bank Fees - 4 Yrs
3. Current Period Amortization: 10,948 4. Dates Incurred: Bonds Issued October 1993Nature of Costs: Start Up Costs - \$278; Bond Fees - \$241,750; Trustee Fee - \$2,222

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>4.4 Acres</u>	<u>1989</u>	<u>\$ 210,330</u>	1
2					2
3	TOTALS			<u>\$ 210,330</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Rosewood Care Center-Moline

0036152

Report Period Beginning:

07/01/1995

Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1990	\$ 2,845,310	\$	40	\$ 71,133	\$ 71,133	\$ 723,185	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Site Improvements			1990	277,100		20-25	11,097	11,097	112,818	9
10	Curbing			1991	2,743		25	110	110	990	10
11	Landscaping			1991	4,560		25	182	182	1,623	11
12	Irrigation System			1993	10,257		25	410	410	2,836	12
13	Water Meter & Back			1993	1,803		25	72	72	492	13
14	Walk-In Cooler			1990	7,845		20	392	392	3,985	14
15	Sinks			1990	6,386		10	493	493	5,782	15
16	Exhaust Hood w/ Fire Extinguisher			1990	6,317		10	524	524	6,317	16
17	Generator			1990	15,779		20	789	789	8,021	17
18	Signage			1990	2,721		15	182	182	1,850	18
19	Facility Signs			1990	1,757		10	153	153	1,757	19
20	Cubicle Curtain Track			1990	6,176		10	511	511	6,176	20
21	Fire Alarm System			1990	99,726		10	8,307	8,307	99,726	21
22	Hot Water Heater			1990	6,706		10	555	555	6,706	22
23	Water Heater Tank			1990	7,961		10	664	664	7,961	23
24	Wallcovering			1990	24,650		10	2,054	2,054	24,650	24
25	Carpeting			1990	8,025		10	664	664	8,025	25
26	Steel Trash Doors			1991	1,825		10	183	183	1,586	26
27											27
28	Leasehold Improvements - Facility										28
29	Painting/Floor Stripping			1995	9,426	1,347	7	1,347		7,242	29
30	Carpeting			1995	292	42	7	42		196	30
31	Carpeting			1996	14,000	2,000	7	2,000		8,833	31
32	Cabinet Work			1996	1,868	267	7	267		1,179	32
33	Base Stripping			1996	1,509	216	7	216		929	33
34											34
35	Continued on Next Page										35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 3,872		\$ 102,347	\$ 98,475	\$ 1,042,865	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Rosewood Care Center-Moline

0036152

Report Period Beginning:

07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Painting			1996	19,996	2,857	7	2,857		10,757	9
10	Wallcoverings/Bathroom Mirrors/Plants			1999	11,651	1,664	7	1,664		2,197	10
11	Drapery/Office Space/Counter			1999	2,256	323	7	323		544	11
12	Wallcoverings			1999	15,783	1,829	7	1,829		1,829	12
13	Carpeting			2000	4,718	107	7	107		107	13
14											14
15	Leasehold Improvements - Managment Company										15
16	Office Construction/Improvements			1995	531		5	106	106	531	16
17	Office Design			1995	49		5	11	11	49	17
18	Office Shelving			1996	113		4	27	27	113	18
19	Office Expansion			1996	501		4	125	125	501	19
20	Office Expansion			1997	1,342		3	426	426	1,342	20
21	Office Expansion			1998	757		3	252	252	449	21
22	Office Addition			1999	374		3	125	125	125	22
23	Door Locks			1999	187		3	36	36	36	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 6,780		\$ 7,888	\$ 1,108	\$ 18,580	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Rosewood Care Center-Moline

0036152

Report Period Beginning:

07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
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18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Rosewood Care Center-Moline# 0036152Report Period Beginning: 07/01/1999 Ending: 06/30/2000**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 616,182	\$	\$ 50,892	\$ 50,892	5-7 Yrs	\$ 513,556	37
38	Current Year Purchases	22,028		2,043	2,043	5-7 Yrs	2,043	38
39	Fully Depreciated Assets	1,653					1,653	39
40								40
41	TOTALS	\$ 639,863	\$	\$ 52,935	\$ 52,935		\$ 517,252	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	HSM Management	Various	Various	\$ 48,841	\$	\$ 8,361	\$ 8,361	5 Yrs	\$ 19,478	42
43										43
44										44
45										45
46	TOTALS			\$ 48,841	\$	\$ 8,361	\$ 8,361		\$ 19,478	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 10,652	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 171,531	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 160,879	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,598,175	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Section Not Applicable	\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	Section Not Applicable	\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

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XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO16. Rental Amount for movable equipm: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____13. /2002 \$ _____14. /2003 \$ _____* If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

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Facility Name & ID Number Rosewood Care Center-Moline

#

0036152

Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☐ NO

SCHEDULE NOT APPLICABLE - ONLY HIRE CERTIFIED AIDES

If "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE _____

B. EXPENSES**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in
your facility. Drop-out costs can only be for costs incurred by your own aides.**C. CONTRACTUAL INCOME**In the box below record the amount of income your
facility received training aides from other facilities\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-Moline# 0036152 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	28,621	\$ 223,037	\$	28,621	\$ 223,037	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		936	14,040		936	14,040	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		30,824	265,666	1,781	30,824	267,447	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				110,366		110,366	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, X-Ray & Other (specify): Lab Fees	39-8				20,391			20,391	13
14	TOTAL			\$	60,381	\$ 523,134	\$ 112,147	60,381	\$ 635,281	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-Moline

STATE OF ILLINOIS

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XV. BALANCE SHEET - Unrestricted Operating Fund.

0036152

Report Period Beginning: 07/01/1999

Ending:

06/30/2000

As of 06/30/2000

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 561,692	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 59,000)	1,050,715		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,470		6
7	Other Prepaid Expenses	2,656		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deferred Income Tax Benefit	19,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,646,533	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	81,498		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(33,813)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 47,685	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,694,218	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 238,436	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	698,623		29
30	Accrued Salaries Payable	150,629		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,039		31
32	Accrued Real Estate Taxes(Sch.IX-B)	113,500		32
33	Accrued Interest Payable	44,172		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	28,000		35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	265,279		36
37	Accrued Rent	55,824		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,607,502	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,607,502	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 86,716	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,694,218	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 76,037	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 76,037	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	177,079	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(166,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 10,679	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 86,716	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Center-Moline

0036152

Report Period Beginning: 07/01/1999

Ending:

06/30/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,541,950	1
2	Discounts and Allowances for all Levels	(3,023,928)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,518,022	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,863,129	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,863,129	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	17,123	13
14	Non-Patient Meals	12,700	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 29,823	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	22,141	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,141	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discount	684	28
28a	Miscellaneous Income	674	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,358	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,434,473	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 787,993	31
32	Health Care	2,524,822	32
33	General Administration	1,173,044	33
B. Capital Expense			
34	Ownership	1,448,596	34
C. Ancillary Expense			
35	Special Cost Centers	145,059	35
36	Provider Participation Fee	65,880	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,145,394	40
41	Income before Income Taxes (line 30 minus line 40)**	289,079	41
42	Income Taxes	(112,000)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 177,079	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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